WMD Clinical Care Course
Registration Form
Salt Lake City Dates

Please Print or Type

Course Date: (check one)
___Friday, January 13, 2006 - University Health Care, John Moran Eye Center
___Saturday, January 14, 2006 - St. Mark's Hospital
___Friday, January 27, 2006 - Pioneer Valley Hospital
___Saturday, January 28, 2006 - LDS Hospital

Name:_____
First, MI, Last

Last 4 digits of SSN:_____

Date of Birth:_____

Job Title:_____

Employer:_____

Phone:_____

Mailing Address:_____

_____

E-mail:_____

Work County:_____ Home County:_____

The following information is collected for research purposes only and is required by Health Resources and Services Administration (HRSA).

Job Description: (check one)
___Physician
___Nurse
___Other:_____

Race/Ethnicity: (check one)
___American Indian or Alaska Native
___Asian
___African American/Black
___Hispanic/Latino/Spanish
___Native Hawaiian or other Pacific Islander
___White/Caucasian
___Other:_____

Gender: (check one)
___Male
___Female

Are you employed at any of the following: (check any that apply)
___Community Health Center
___Mental Health Center
___Healthcare for Homeless
___Public Housing Primary Care Grantees
___Rural Health Clinic
___Indian Health Services/ Tribal Health Site
___Health Department
___Governor Designated Area
___Urban Community Based Training Site
___Other Area Health Education Center (AHEC) Community Based Site
___Hospital

Fax or mail the completed registration form to:
BNICE Training Center
777 Bannock St., MC8800
Denver, CO 80204
Fax: 303-436-5034

Confirmation letters will be emailed.
Questions: Email info@bnice.org or call 303-436-5075 or 801-538-6614.